



City of San Antonio

Authorization Agreement for Pre-Arranged Payments (ACH Debits)

Name: _____
Last Name First Name MI

Address: _____
Street City State Zip

Cell Phone: () Home Phone: ()

SAP #: _____ Status (please check one): ☐ Retiree ☐ Leave of Absence
☐ Military ☐ Other (please specify):
☐ Active

I (We) hereby authorize the City of San Antonio, hereafter called the City, to initiate debit entries to my (our) checking or savings account as indicated below and the depository names below, hereafter called the DEPOSITORY, to debit the same to such account. It is understood that such debits will be applied as payment of premiums to the City's group benefit plans in accordance with the options selected.

Depository Name: _____

Branch: _____
City State Zip

Transit / Routing No. _____ Account No. _____

Checking ☐ Savings ☐ (Check one)

This authority is to remain in full force and effect until the City and Depository have received written notification from me (or either of us) of its termination in such manner as to afford the City and the Depository a reasonable opportunity to act on it. I (or either of us) have the right to stop payment of a debit entry by notification to the Depository as such time as to afford the Depository a reasonable opportunity to act on it prior to charging the account. After account has been charged, I have the right to have the amount of an erroneous debit immediately credited to my account by the Depository, provided I (We) send written notice of such debit entry in error to the Depository within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first.

Name(s) _____
Please Print

Date _____ Signed _____ Signed _____

Attach a blank, voided check or deposit slip to this form and submit with your Benefit Election Form and mail to the following address:

City of San Antonio
Employee Benefits Office
115 Plaza de Armas Suite 20
San Antonio, TX 78205

For questions, contact:
210-207-8705

Or Fax to: 210-207-2176

Fiscal Use Only:

Effective Date _____

Initials

Date

Master Data Update: _____

File: _____

Copy to Fiscal

Copy to Benefits

Copy to Enrollee